DOCUMENT RESUME

ED 217 343 CG 015 949

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TITLE Neighborhood Age Structure and Support Networks.
SPONS AGENCY National Inst. of Mental Health (DHHS), Bethesda, Md.
PUB DATE Nov 81
GRANT NIMH-1-RO1-MH-32999
NOTE 41p.; Paper presented at the Joint Annual Meeting of the Scientific Gerontological Society (34th) and the Scientific & Educational Canadian Association on Gerontology (10th), (Toronto, Ontario, Canada, November 8-12, 1981). Best copy available.

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS Age Differences; *Age Groups; Community Characteristics; Friendship; *Helping Relationship; *Housing; Middle Aged Adults; *Neighborhood Integration; Neighborhoods; Older Adults; *Peer Groups; Population Distribution; *Residential Patterns

ABSTRACT

Studies conducted in specifically age-segregated housing for older persons suggest that such age-homogeneous settings encourage networks of friendships and mutual assistance. Since patterns of age segregation exist within communities, such segregation may result in similar social benefits. Interviews (N=1,185) assessing social networks were conducted with persons aged 60 and older. Two measures of neighborhood age structure were used to determine the age segregation of neighborhoods. Results indicated that, although children were preferred for instrumental and expressive supports, neighbors were frequently used for both types of support and were substituted for unavailable children for instrumental help. Whether neighbors were chosen for instrumental or expressive help appeared to contribute little to overall well-being. General involvement in neighborhood networks showed similar patterns. Closest neighbors and neighbors who were confidants tended to be age peers, with age being less important for instrumental or emergency help. Living in an age-segregated neighborhood had little relation to getting instrumental or expressive support from neighbors or to general involvement with neighbors. The results provide little evidence that residential age segregation contributed to overall well-being. (NRB)

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NEIGHBORHOOD AGE STRUCTURE AND SUPPORT NETWORKS*

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*Research reported here was funded under NIMH Grant 1 ROI MH32999.

CG 015949

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NEIGHBORHOOD AGE STRUCTURE AND SUPPORT NETWORKS

Studies conducted in a variety of age-segregated living arrangements for older people--"single-room occupancy" hotels, apartment complexes, mobile home parks, and retirement communities--suggest that such settings have a number of beneficial consequences (see Ward (1979b) for a review of this literature). In particular, networks of friendship and mutual assistance appear to be enhanced by age homogeneity. Other patterns of age segregation exist within communities, as there is evidence of substantial residential age segregation in American metropolitan areas (Cowgill, 1978; Kennedy and DeJong, 1977; LaGory et al., 1980; LaGory et al., 1981; Pampel and Cholden, 1978; Smith and Hiltner, 1975). These patterns are attributable to lower income of the aged and an associated disadvantage in housing competition, ecological processes of urban growth, and choices related to the family cycle. The research reported here investigates whether such segregation has social benefits similar to those of specifically age-segregated housing. A number of perspectives suggest that this may be the case.

THE IMPORTANCE OF NEIGHBORHOOD SETTING

The concept of "environmental docility" (Lawton and Nahemow, 1973) suggests that older people may be more dependent on, and less able to manipulate, the environment. Similarly, it has been suggested that "person/environment congruence" is particularly critical to the well-being of older persons (Kahana, 1975; Lawton, 1980). This highlights the importance of viewing the neighborhood as a behavioral context for the elderly. While the range of modern assistance relationships has expanded to include differentiated networks which encompass an entire metropolitan area (Wellman, 1979), the reduced mobility of older people

and the tendency of many inner-city elderly to be "block-bound" means that the aged "must rely on the local area and its inhabitants to support their needs, while most of today's society reach far from home to meet the needs of everyday life" (Carp, 1976: 249).

Characteristics of the neighborhood, rather than of the dwelling unit per se, are most decisive in shaping housing satisfaction of the aged. Neighborhood social composition is a particularly critical neighborhood characteristic because older people tend to draw their friends from a more narrowly local area (Lawton, 1980; Riley and Foner, 1968; Rosenberg, 1970). The quality of neighborhood relationships has been found to be an important dimension of neighborhood satisfaction for older persons (Bohland and Davis, 1979: Branch, 1978; Mathieu, 1976; Toseland and Rasch, 1978), and age similarity appears to be an important factor in this regard. Kendig (1976) suggests that age and class congruency facilitate social contact, which in turn is related to morale and mental health. Lawton and Nahemow (1978) found that a greater proportion of older people in the neighborhood was associated with greater participation in activities, housing satisfaction, and interaction with fellow tenants; similarly, Berghorn et al. (1978) found that age concentration was associated with higher morale.

THE IMPORTANCE OF AGE SIMILARITY

The importance of neighborhood age composition is related to the more general role of age similarity in friendship formation. A number of studies report that people tend to choose friends of their own age (Hess, 1972; Lowenthal et al., 1975; Powers and Bultena, 1976: Riley and Foner, 1968; Stueve and Gibson, 1977). Age has long been considered a focal point for the development of social networks (Simmel, 1955). Friendships are highly voluntary, emphasizing peership/similarity (Hess, 1972· Lowenthal et al., 1975), and both cohort membership and stage in the life course create shared interests and needs. The importance

of age as a basis of friendships may be greatest in old age, when ties to other, age-mixed networks are loosened because of more restricted and age-linked roles (Hess, 1972: Lowenthal and Robinson, 1976)..

A number of factors promote age similarity in social relations: shared experiences, similar work and family positions, role transitions occurring at about the same time, relative equality in resources and authority, residential segregation, cultural expectations (Stueve and Gibson, 1977). A member of "pressures" may heighten the salience of age-homogeneous peer groups in later life, including aging subcultures revolving around leisure and socialization for old age, retirement and consequent reduced diversity of role sets, economies of scale which encourage age-homogeneous housing, and ageism (Dono et al., 1979). Age homogeneity may arise from a desire to select an "audience" which facilitates identity maintenance (George, 1980), Dowd (1980a, 1980b) places the issue of age homogeneity more explicity within an exchange theory framework; age homogeneity minimizes the costs of social exchange, bringing together similar interests and resources, and makes it easier to determine routine expectations and rules for exchange.

NEIGHBORS AND SUPPORT NETWORKS

Neighborhood age structure, of course, will be important only to the extent that social networks make significant contributions to well-being, and that neighbors constitute an important component of social networks. Social networks serve as linkages by which individuals receive information and assistance. Cobb (1976) characterizes social supports as "communicated sharing", whereby information is received that one is cared for, esteemed, and belongs to a network of communication and mutual obligation. Kahn (1979) cites affect, affirmation, and aid as the elements of supportive transactions. There is evidence that social support facilitates coping and adaptation, either directly or indirectly as a stress-buffering system, through its instrumental and expressive functions (Cobb,1976;

Dean and Lin, 1977; Kessler, 1979; Lin et al., 1979). Cobb (1979) hypothesizes that social supports reduce stress by improving person/environment fit, as people who feel esteemed feel more confident and better able to exercise environmental control.

There is certainly reason to believe that social supports will be related to well-being in later life. Stability in friendship networks lends a sense of continuity of self (Lowenthal and Robinson, 1976), and friends fulfill many socialization functions--emotional support during role transitions, information about roles, and mutual opportunities for role rehearsal (Hess, 1972). External support and socialization bolster a sense of internal control which is important to effective coping (George, 1980). Older people may also be especially dependent on the "lay referral" network for access to services (Ward, 1977).

The social networks of older persons may be characterized by reduced size and increased instability because of role loss and limited mobility due to declining income and health (Kahn, 1979; Ward, 1979a; Wood and Robertson, 1978). Empirical results concerning the importance of social activity are neither clear-cut nor consistent, however, (Conner et al., 1979; Larson, 1978; Wood and Robertson, 1978). While some find relationships between social integration/interaction and morale/adjustment, others do not. This may reflect a failure to link types of support functions with types of social relationships.

There is disagreement about the relative importance and functions of different components of the social networks of older persons. Cantor (1979), studying ten hypothetical situations, found that kin, preferably children, were clearly the first choice for assistance, followed by friends and neighbors, who were used substantially with regard to sociability and loneliness. She characterizes social networks as "hierarchical-compensatory", with other relatives, friends, and neighbors being turned to only as children are increasingly more removed. Others view social networks as "task-specific", however, with primary groups differentiated

structurally according to the types of tasks they can handle most effectively (Dono et al., 1979; Litwak and Szelenyi;1969). Kin groups are characterized by permanent membership, but differential mobility. This impedes face-to-face contact, but modern systems of communication, transportation, and monetary exchange allow maintenance of ties over distances. Kin groups function best in tasks involving long-term ties of reciprocity. But the obligatory nature of kin relations may detract from their quality, and kin may be estranged by generational differences in interests and experiences, yielding relatively symbolic and ritualistic interactions (Wood and Robertson, 1978). Friendships, because of their voluntary nature and basis in similarity and consensus, may yield greater openness of communication and intimacy (Adams, 1967). The structure of neighborhoods emphasizes proximity and face-to-face contact, but also nonpermanent membership; the most appropriate functions relate to speed in responding to emergencies, services based on territoriality, and everyday observation for learning (socialization) (Litwak and Szelenyi, 1969). To the extent that low income or poor health limit mobility, older people may be particularly dependent on the local area for social contacts (Dono et al., 1979). Indeed, some studies have found that interaction with friends and neighbors is more strongly related to morale than interaction with family (Arling, 1976; Pihlblad and Adams, 1972). Since age is often a basis for friendships, neighbors who are age peers may combine the "advantages" of neighbor and friend, making their availability particularly valuable.

Some research suggests that informal neighboring and social bonds decline with age (Hunter, 1975; Kasarda and Janowitz, 1974). Lopata (1973; 1975), for example, found that neighboring was limited to only casual contacts outside of residences for her inner-city sample of older women. But there is other evidence of local support systems for the aged (e.g. Cantor, 1975; Carp, 1975). Cantor (1979), in a study of New York City elderly, found that 62% knew at least one neighbor well: over one-half were involved in functional social support relations

with neighbors. These exchanges exhibited high reciprocity, involving both instrumental and expressive support. Lopata (1979) found that while little support is exchanged with neighbors who are not considered friends, neighbors are a primary source of both old and new friends for widows.

The research reported here addresses two issues concerning such neighborhood support networks. First, what role does age segregation, or neighborhood age structure, play in fostering social support networks within neighborhoods? Second, how, and through what processes, do such networks affect the well-being of older persons?

METHODS

Sample

To investigate the nature and consequence of neighborhood support networks, a sample of persons 60 and over in the Albany-Schenectady-Troy, New York, SMSA was interviewed. Residential age segregation in this SMSA is somewhat lower than average, but within one standard deviation of the mean (LaGory et al., 1981). To insure an adequate range of neighborhood age structure, census tracts were first stratified according to percent aged 60 and over, as follows: 1) Stratum 1, less than 13% aged 60+ (35 tracts, 9.7% of those 60+ in the SMSA); 2) Stratum 2, 13-21% aged 60+ (88 tracts, 16.4% of those 60+ in the SMSA); and 3) Stratum 3, 21% and greater aged 60+ (31 tracts, 23.9% of those 60+ in the SMSA). Blocks were then sampled proportionate to their size within each stratum; starting at a designated household, up to three respondents were interviewed on each block. A total of 1,185 interviews were completed (456 in Stratum 1, 386 in Stratum 2, and 343 in Stratum 3). The average age of respondents was 70.6, with 61% female and 96% white. In terms of location in the "urban hierarchy", 46% resided in one of the three central cities, 27.8% were "suburban" (Urbanized Area or noncontinguous small city), and 26.2% were "rural" (largest place 5,000 population).

Instrumentation

Demographic information for each respondent includes age, sex, marital status (50.3% married, 38.7% widowed), employment status, occupation (and occupational prestige), education, and income. A scale of functional health measured ease of going outdoors, walking up and down stairs, getting about the house, and doing cleaning and household chores (the first three are from the physical incapacity index used by Shanas et al., 1968). This sample is quite able in terms of mobility and tasks of daily living, as 70.2% indicated they could do all four by themselves without difficulty.

Of particular interest here are the measures of social networks utilized in the survey. Cantor (1979) suggests that support systems must fulfill three major needs--socialization, carrying out tasks of daily living, and assistance during crisis. These represent both instrumental and expressive dimensions of support. Cantor also cites three components of informal personal support--kin, close friends or intimates, and neighbors. Each of these aspects of support were assessed in the interview.

Instrumental support in tasks of daily living is assessed by asking respondents who, other than spouse, they would turn to in four hypothetical situations (look in and see how you are doing, give a ride to go shopping or see the doctor, get something from the store, look after the house while you are away). Respondents are also asked who these persons are (family, friend, etc.), their age and sex, and whether they live in the neighborhood, and generally whether they have enough persons to turn to in such situations.

Drawing from Wellman (1979) and Cantor (1979), who stress closeness and sharing of confidences and feelings in defining "confidants", respondents were asked if there is "anyone--friends, neighbors, or relatives--that you feel very close to--someone you share confidences and feelings with?", and how many such persons they have outside the household. For the (up to three) confidants they

feel closest to, respondents also indicated the person's relationship, age, sex, location (proximity), frequency of interaction, religion, ethnicity, education, and length of the relationship. Respondents were also asked whether they have enough opportunities to share confidences with someone.

While family, friends, and neighbors may be cited in the previous sets of questions, additional questions were directed specifically at each of these types of relationships. Respondents were asked how many living children they have, their location and interaction frequency, and whether they see their children often enough. They also indicated the number of other relatives in the area, how many of these are seen or heard from regularly, and how many nonneighbor friends they have in the area.

More detailed questioning focussed on neighbors. Respondents indicated how many neighbors they knew well enough to visit with in their homes, and the age, sex, religion, education, and ethnicity of the (up to three) they are friendliest with. They were also asked how many neighbors they relied on in emergencies and whether most of these are over 60, how often they interact with neighbors, and whether they see neighbors often enough. Respondents were asked which of six types of assistance they ever gave to neighbors, and which of these their neighbors ever did for them; these items parallel the general instrumental and confidant questions occurring earlier in the interview. More broadly, respondents were asked to "rate this neighborhood as a place to live" (excellent, good, fair, poor), and how much they have in common with their neighbors, how happy they are with the kind of people living in the neighborhood, and whether they have difficulty making close friends in the neighborhood.

Two measures of neighborhood age structure are utilized: 1) the percentage of tract residents age 60+, based on 1970 tract statistics (PCT 60) (mean=16.5, range=3.6-35.0, standard deviation=6.2 and 2), the respondents s estimate of the following-- of all the people who live in your neighborhood, what proportion

(percentage) would you say are about 60 years or older?" (PCTOP) (mean=30.5, range=0-100, standard deviation=24.3). PCT60, an objective measure covering a broad area, and PCTOP, a subjective measure more locally based, are moderately correlated (r=.29), indicating that they are similar but distinct measures of neighborhood age structure. Both measures are strongly related to type of tract, since the elderly tend to concentrate in central-city areas with older, lower value, multi-unit housing (LaGory et al., 1981) (mean PCT60: city=21.7, suburb=12.2, rural=11.7; mean PCTOP: city=37.0, suburb=28.9, rural=22.7). To avoid confounding the effects of metropolitan location with those of age segregation, analyses were also run separately for the three types of tracts; these results will be referred to as appropriate.

Three variables are used to measure the "outcome" of social support. It was expected that persons with stronger social networks would have greater access to information about services. Similar to the approach taken by Bild and Havighurst (1976), knowledge of five services for older people known to exist throughout the survey area was assessed. Global well-being was measured by the Philadelphia Geriatric Center Morale Scale (Lawton, 1975). Finally, it has been suggested that the coping ability of older people is dependent upon their social context (Kuypers and Bengtson, 1973). This research utilizes a Mastery scale developed by Pearlin and Schooler (1978) to measure the "extent to which one regards one's life chances as being under one's own control".

RESULTS

The research reported here is directed at the role of neighbors generally, and neighbors aged 60+ specifically, in the support networks of older people. The results are presented with the following organization. First, are neighbors important sources of instrumental aid and does this vary with neighborhood age structure? Second, do neighbors play an important role as confidants and does

neighborhood age structure affect this role? Third, does neighborhood involvement more generally contribute to well-being, and is neighborhood age structure influential in this regard?

Instrumental Assistance

From 90.7% to 92.5% of respondents indicate someone they could turn to in each of the four instrumental situations with 86% having help for all four situations. Among those with help available, children are favored, being chosen by 38.2% to 42.4%. Friends or neighbors (these are virtually all neighbors) represent the second most prevalent choice in all four situations, however (28.4% to 33.7%); neighbors are chosen for all four situations by 20%, while 59% indicate neighbors for none of the situations. Table 1 indicates that neighbors are most likely to substitute as children are less accessible, except that neighbors and other relatives are chosen about equally by those with no children. There is little evidence of mixing of types of helpers across situations, indicating that the same person is likely to be turned to for all four. When neighbors are indicated, from 39% to 42% of these are aged 60+. Among all respondents, about 12% name a neighbor aged 60+ for each situation, with 18% indicating such a neighbor for at least one situation. As indicated in Table 2, measures of neighborhood interaction and of assistance actually received from neighbors are related to having someone to turn to in the instrumental situations, and particularly to choosing neighbors.

(Tables 1 and 2 about here)

Neighbors are indicated in more situations by younger respondents (r=-.09 with age) and those with better functional health (r=.07). There are stronger relationships with higher socioeconomic status (occupational prestige=.14, income=.14, education=.19); for example, over 50% of respondents in blue-collar occupations indicate children, compared with one-third of those in white-collar occupations. Age, functional health, income, and occupational prestige are unrelated

to naming a 60+ neighbor, though education is related (r=.13). Widowhood is not related to type of helper chosen. Suburban residents are more likely to indicate a neighbor for at least one of the situations than are city or rural residents (Table 3), but there is no relation with naming a 60+ neighbor. Number of years residing at current address is unrelated to choosing neighbors or 60+ neighbors. Among those with less than ten years at the same address, however, number of years in the neighborhood is related to naming a neighbor (r=.12) and particularly to naming a 60+ neighbor (r=.25; 8% of those living in the neighborhood for 10 years or less, versus 30% of those over 10 years). Naming neighbors or 60+ neighbors shows little relation with overall ratings of the neighborhood.

Neither PCT60 nor PCTOP is related to having someone to turn to in the instrumental situations or naming neighbors. Among those who have someone to turn to, PCT60 is weakly related to naming a 60+ neighbor (r=.10). There is a stronger relationship between this and PCTOP (r=.19) (Table 4).

Naming neighbors or 60+ neighbors as potential helpers is unrelated to feeling that one has "enough" help. Similarly, both show little relationship to morale, mastery, or knowledge of services.

It appears, then, that neighbors have some importance as instrumental helpers, particularly to the degree that children are not proximate. The proximity of neighbors make them well-suited for such tasks, and they substitute for children to a greater extent than do other kin. When children are available, however, they are the preponderant choice for instrumental assistance. Neighborhood age structure has little impact on use of neighbors, except with regard to naming a neighbor aged 60+. Finally, whether neighbors are chosen, generally or aged 60+, rather than some other source does not appear to affect well-being.

Confidants

Nearly one-fourth (22.8%) of the sample had no confidant outside of the

household (mean=3.0). Family members are most frequently chosen; 69% have at least one of their (up to three) cloest confidants who is a family member (including 38% with at least one child, 23% a sibling, and 27% other relative), and 51% name only family members. Neighbors are the second most prevalent type of confidant after children; 36% name at least one neighbor as a confidant, and 21% name only neighbors. As with instrumental assistance, children are named as confidants when available, but in this case other relatives (including siblings) are more likely than neighbors to "substitute" when children are less accessible (Table 5). The extent to which children are favored when available is less pronounced than with instrumental help, however.

(Table 5 about here)

Nonkin confidants are more likely to be 60+ than are nonkin instrumental helpers; about 60% of confidants who are friends or neighbors are aged 60+. Of those with any confidant, 24% name at least one 60+ neighbor. Among those who name a neighbor as a confidant, 68% name at least one 60+ neighbor.

Neither naming a neighbor nor a 60+ neighbor as a confidant is related to age, functional health, socioeconomic status, or length of residence, but the neighbors indicated by older respondents tend to be older (r=.13). Neighbors are most often named by rural residents, and least often by city residents (Table 6). As was also true of instrumental support, measures of neighborhood interaction and assistance are related to number of confidants, naming a neighbor, and naming a 60+ neighbor (Table 7). Overall neighborhood rating, however, is not related to whether the respondent indicated a neighbor or 60+ neighbor as a confidant.

(Tables 6 and 7 about here)

PCT60 and PCTOP are related to neither number of confidnats nor naming a neighbor as a confidant. Indicating a 60+ neighbor is weakly related to PCTOP (r=.07) and is generally unrelated to PCT60, except for suburban respondents (r=.14). Among respondents having at least one heighbor as a confidant, however,

PCT60 (r=.16) and PCTOP (r=.23) are both related to having a 60+ confidant (Table 8). The associations for PCTOP are particularly strong for respondents with some impairment in functional health (r=.57), aged 70+ (r=.33) and living in an apartment (r=.54) (though numbers of respondents are small in these breakdowns).

(Table 8 about here)

While proximity of closest confidant and average proximity of all confidants named are related to morale (correlations, controlling functional health, occupational prestige, and education, are .11 and .10, respectively; these associations are somewhat stronger for rural residents and those with some functional impairment), these are not related to mastery, and naming a neighbor is related to neither morale nor mastery. Having a neighbor as a confidant is also not related to knowledge of services, except for rural respondents (partial correlation=.15). Finally, whether a 60+ neighbor is indicated as a confidant is unrelated to the measures of well-being.

To summarize, neighbors represent an important source of confidants, though their prevelance is less than for instrumental help and they do not "substitute" for children. Such neighbors are typically age peers, while younger neighbors are used more often for instrumental assistance. Neighborhood age structure is generally unrelated to availability or type of confidant, except that neighbor confidants are older in age-segregated areas. Finally, having confidant neighbors, regardless of their age, appears to have little effect on well-being.

Neighbors

About one-third (35%) of the respondents do not know any neighbors well enough to visit with (mean=3.5), and 28% have no neighbors they could rely on in emergencies (mean=2.5). On average, respondents have been helped by and have helped neighbors on about half of the six neighborhood assistance items. The mean

age of neighbors known best is 57; among those who know any neighbors well, 67.4% indicate at least one aged 60+ and 34.3% indicate that all of their (up to three) closest neighbors are aged 60+. Among those who have neighbors to turn to for help in emergencies, however, only 35.9% indicate that most of these neighbors are aged 60 or older.

Older respondents know fewer neighbors (r=-.11) and receive less assistance from neighbors (r=.10), and neighbors they know best are older, both average age (r=.14) and percent 60+ (r=.12). Better functional health is related to knowing more neighbors (r=.10), receiving more help from neighbors (r=.06), and having more neighbors to turn to in emergencies (r=.10), but is unrelated to interaction frequency or age of closest neighbors. Higher socioeconomic ststus is generally related to number known and help received (r=.12-.15, depending on SES indicator), but is not related to frequency of interaction or age of closest neighbors. Widowhood exhibits little association with these neighborhood variables. Length of residence is related to number of neighbors known well (correlation=.09, controlling functional health, occupational prestige, and education) and help received (partial=.15), but is otherwise unrelated to these variables. Type of tract is related to both neighborhood involvement and age of closest neighbors (Table 9). In general, rural residents know more neighbors and receive more help, while city residents are lowest on these; frequency of interaction with neighbors is unrelated to type of tract, however. The closest neighbors of rural respondents are also younger, and they are less likely to say that most of the neighbors they would turn to in emergencies are 60+ (rural=20.4%, suburban=40.9%, city=43.6%; p=.0001).

(Table 9 about here)

Frequency of interaction with neighbors is associated with higher average age (r=.07) and higher percent 60+ (r=.10) among closest neighbors. Other neighbor variables, including perceived commonality with neighbors, exhibit little association with age of neighbors indicated. While overall neighborhood rating is

related to more general neighbor characteristics--number known well (r=.10), number for emergencies (r=.13), help received (r=.09), and amount perceived in common (r=.19)--this is not related to the age of neighbors respondents are friendliest with.

PCT60 has little or no relation to number of neighbors known, number for emergencies, perceived commonality, or help received. Among apartment dwellers in cities, however, frequency of interaction with neighbors is related to PCT60 (correlation=.21, controlling functional health, occupational prestige, and education). PCTOP exhibits the same patterns, except that PCTOP is also related to amount perceived in common with neighbors (partial correlation=.15), and to number available for emergencies for rural residents (.22). Both measures of neighborhood age structure are related to age of neighbors turned to in emergencies (r=.18 for PCT60 and .31 for PCTOP).

The clearest relationships for neighborhood age structure are with the ages of neighbors respondents are friendliest with. PCT60 is related to higher average age (r=.13) and percent 60+ (r=.18); the association with average age is stronger for respondents who are aged 70+ (.17) or have some functional impairment (.21), but is not significant for rural residents. PCTOP has stronger relations with average age (r=.32) and percent 60+ (r=.34), especially for respondents with some functional impairment, apartment dwellers, and those who have lived in the neighborhood for three years or less (e.g., correlations of these with percent 60+ are .52, .45, and .52, respectively). Whether any 60+ neighbor is named is also related to both PCT60 (r=.14) and PCTOP (r=.31) (distributions are shown in Table 10).

(Table 10 about here)

The relationships of neighbor variables with well-being, controlling for health and SES, are indicated in Table 11 With the exception of whether neighbors are seen "enough", neighborhood involvement and age of neighbors respondents are

friendliest with exhibit small or insignificant associations with morale, mastery, and knowledge of services. There are categories of respondents, however, for whom such factors are of greater importance. Morale, for example, has a stronger relation with frequency of interaction with neighbors among respondents who: have some functional impairment (.16), are city residents (.14), live alone (.15), are widowed (.15), have lived in the neighborhood for three years or less (.19), and have no living children (.22); morale is also more strongly related to whether neighbors are seen enough for city/apartment dwellers (.29) and short-term residents (three years or less) of neighborhood (.32). Similar patterns are evident with mastery; for example, there are stronger relationships with interaction frequency for city residents (.13), those with some functional impairment (.13), widowed respondents (.11), and short-term residents (.27). In terms of knowledge of services, city residents who live in apartments exhibit associations with number known, frequency, and whether neighbors are seen enough (partial=.14 with all three), and with help received (.18); similarly, respondents with some functional impairment have an association between service knowledge and both frequency and whether neighbors are seen enough (.14). Age of closest neighbors has little relation to well-being except with regard to service knowledge. Having at least one close neighbor aged 60+ has a stronger association with knowledge of services for city residents (.16), apartment dwellers (.17), and persons living in a neighborhood for three years or less (.20).

(Table 11 about here)

Multiple regression was used to further assess the contribution of neighborhood involvement, generally and with 60+ neighbors, to well-being. In the first analysis (Table 12), the following groups of variables were entered in stepwise fashion: 1) functional health, education, occupational prestige, non-neighbor social ties (number of children, other relatives, and friends in the SMSA), number of instrumental situations for which there is someone to turn to,

and number of confidants; 2) number of neighbors known well enough to visit with, frequency of interaction with neighbors, and help received from neighbors; and 3) indicating a neighbor as a confidant or instrumental helper. It is evident from this first analysis that morale is most closely associated with functional health and socioeconomic status, with social ties and instrumental assistance also being significant. Neighbor variables, with the rather modest exception of interaction frequency, add little to the model.

(Table 12 about here)

The second regression analysis investigated the impact of having a 60+ neighbor as confidant, instrumental helper, or close neighbor, entering these variables into the equation after functional health, SES, social ties (now including number of neighbors known well), and instrumental/confidant support. It appears that age peer neighbors make no unique contribution to morale (Table 13). Having a close 60+ neighbor, however, is significantly associated with knowledge of services. Finally, the analysis reported in Table 14 investigates whether seeing neighbors "enough" contributes to morale independently of social ties (including number of neighbors known), instrumental and expressive support available, and whether instrumental helpers reside in the neighborhood (either neighbors or relatives). This subjective experience of neighboring does appear to make a unique contribution to morale.

(Tables 13 and 14 about here)

The results for neighbors indicate that the majority of these respondents are involved in networks of interaction and support with neighbors. There is a clear tendency to interact most closely with neighbors who are age peers, though less so for emergency assistance (reflecting a similar comparison between confidants and instrumental helpers). Neighborhood age structure has generally small associations with neighborhood involvement, except for certain types of respondents. Neighborhood age structure has more substantial relationships with the age of neighborhood networks. While neighborhood involvement generally makes little

independent contribution to well-being, there are categories of respondents for whom this is more influential. Any unique contribution of involvement with neighbors who are age peers seems to be restricted to knowledge of services.

DISCUSSION

The issues of primary interest in this research concern the role of neighbors, and particularly neighbors who are age peers, in the support networks of older persons, and the influence of neighborhood age structure on these roles. The results indicate that when children are accessible they are favored for both expressive and particularly instrumental support. Neighbors are frequently used for both types of support, however, and appear to be the favored "substitute" for children for instrumental help. On the whole, this provides some support for the "hierarchical-compensatory" model of informal supports, at least for instrumental assistance. Whether neighbors are chosen for instrumental or expressive support appears to contribute little to overall well-being. General involvement in neighborhood networks exhibits similar patterns, except that interaction with and assistance from neighbors appears to be important for certain segments of the older population (e.g., poor health, apartment dwellers, recent movers). Thus, it appears that neighbors per se are relatively unimportant to well-being generally, whether one speaks of quantity (number, frequency) or quality (types of support), but greater attention needs to be paid to the varying roles of social relationships within subgroups of older people. It is noteworthy that whether neighbors are seen "enough" is more important to morale than how often they are actually seen. Subjective elements of social networks may be most critical in shaping subjective well-being.

Closest neighbors and neighbors who are confidants tend to be age peers, but age appears to be less important for instrumental or emergency support. Whether or not age peer neighbors are part of one's social network, however, appears to

have little impact on well-being. These results bear on the "homophily principle" (Homans, 1950; Laumann, 1966; Laumann and Senter, 1976; Verbrugge, 1979), which asserts that social relationships tend to occur among persons with similar characteristics. Age represents a similarity which does appear to structure close relationships, but whether such homophilous structuring occurs does not seem to affect subjective well-being. The finding that having close older neighbors is related to service knowledge, however, indicates that homophilous networks may have unique benefits when attribute similarity is specifically relevant to some outcome.

Finally, neighborhood age structure was found to be influential in some respects, but not others. Living in an age-segregated neighborhood had little relation to having instrumental support or neighbors as helpers, having confidants or neighbors as confidants, or general involvement with neighbors. Both measures of neighborhood age structure were generally related to naming 60+ neighbors as instrumental helpers or confidants, and naming older neighbors among those one is friendliest with. Thus, residential age segregation appears to stimulate operation of the homophily principle, but there is little evidence here that it contributes to overall well-being. A basic issue, then, is: why is this type of age segregation apparently less influential than that found in retirement communities, old-age apartments, and the like?

One possibility involves the measures of neighborhood age structure. PCTOP typically exhibited stronger relationships than PCT60, as one would expect given that PCTOP taps a more localized context. But PCTOP is also a subjective measure which may represent at least partly a <u>reflection</u> of one's neighborhood network. PCT60 is a more objective measure, but the ten year lag between the 1970 census and our survey makes the validity of this measure questionable. Fortunately, 1980 census data should soon be available for incorporation into our analysis.

It may also be true, however, that the age segregation studied here has quite

different implications. Neighborhood age segregation differs quantitatively and qualitatively from that found in specifically age-segregated settings. The extent of age segregation is much less pronounced. Unlike retirement communities, these age-segregated neighborhoods are not chosen as such nor are they "self-enclosed", thereby lacking a built-in incentive to construct a "community", and they do not necessarily attract or include age peers who are as socially homogeneous in other ways as are residents of retirement communities. Additionally, many older people neither need nor desire access to networks of age peers; they do not wish to identify themselves as "old" nor identify with such persons (Bultena and Powers, 1978). There is some evidence here, however, that the networks of certain types of older people (e.g., those with functional impairments, apartment dwellers, recent movers) are affected more by neighborhood age structure. Thus, attention needs to be given to sources of variation in the sensitivity of older persons to local context, both physical and social.

Table 1. Who would "look in on you and see how you are doing", by proximity of nearest child.

	Nearest Child:				
	No Children	Outside SMSA	In SMSA	Same Neighborhood	Same House or Building
No one	11.0%	9.7%	4.5%	2.3%	4.1%
Child	0%	9.0%	57.5%	79.7%	63.1%
Other relative	40.8%	23.4%	10.8%	5.6%	8.3%
Friend/neighbor	42.7%	54.5%	25.5%	10.2%	23.0%
Other	5.5%	3.4%	1.7%	2.3%	1.4%
	100%	100%	100%	100%	100%
N	255	145	353	177	217

X^2=445.7 (16 df), p=.0001

Table 2. Partial correlations (controlling functional health, education, and occupational prestige) of instrumental assistance with neighborhood involvement.

# of situations:	# Neighbors Known	Neighbor interaction frequency	Help received from neighbors
Anyone to turn to	.09	.06	.17
Neighbors chosen	.10	.18	.35
Neighbors 60+ chosen	ns	.16	.22

Table 3. Choosing a neighbor as instrumental helper, by type of tract.

Neighbors chosen:	City	Suburb	Rural
None	60.6%	52.2%	63.3%
1 or more	39.4%	47.8%	36.7%
	100%	100%	100%
N	426	274	281

$X^2=7.9$ (2df), p=.05

Table 4. Relationship between PCTOP and naming a 60+ neighbor as instrumental helper.

	PCTOP		
Name 60+ neighbor	1-10%	11-29%	30+%
No	89.7%	81.2%	73.2%
Yes	10.3%	18.8%	26.8%
	100%	100%	100%
N	242	117	306

X^2=23.5 (2df), p=.0001

Table 5. Type of person named as closest confidant, by proximity of nearest child.

	Nearest Child:				
	No Children	Outside SMSA	In SMSA	Same Neighborhood	Same House or Building
Child	0%	25.2%	48.3%	49.7%	27.5%
Sibling	28.2%	18.7%	10.3%	10.1%	16.3%
Other relative	29.8%	13.1%	8.6%	8.7%	13.7%
Neighbor	28.2%	28.0%	23.4%	24.8%	28.1%
Friend	13.3%	15.0%	9.3%	6.7%	14.4%
	100%	100%	100%	100%	100%
N	181	107	290	149	153

X^2=171.1 (16df), p=.0001

Table 6. Frequency of naming a neighbor as confidant, by type of tract (for respondants with any confidant).

Neighbors named:	City	Suburb	Rural
None	68.6%	62.4%	59.0%
1 or more	31.4%	37.6%	41.0%
	100%	100%	100%
N	404	255	239

X^2=6.5 (2df), p=.05

Table 7. Partial correlations (controlling functional health, education, and occupational prestige) of confidant variables with neighborhood involvement.

	# Neighbors known	Neighbor interaction frequency	Help received from neighbors
# of confidants	.20	.10	.17
Neighbors named	.11	.19	.22
Neighbors 60+ named	ns	.13	.13

Table 8. Naming a 60+ neighbor as a confidant by neighborhood age structure (for respondents naming at least one neighbor confidant).

60+ neighbor as confidant	PCT60			PCTOP		
	2-11%	12-22%	23+%	2-10%	11-29%	30+%
No	42.6%	29.7%	21.1%	46.1%	27.7%	23.4%
Yes	57.4%	70.3%	78.9%	53.9%	72.3%	76.6%
	100%	100%	100%	100%	100%	100%
N	94	148	57	76	47	107
	X^2=8.3 (2df), p=.05			X^2=11.0 (2df), p=.005		

Table 9. ANOVA of neighborhood variables with type of tract[1].

	Rural	Suburb	City	
# neighbors known[2]	5.5	3.4	3.1	b=.15
# for emergencies[2]	3.1	3.0	2.3	b=.09
# types of help received[2]	3.3	3.1	2.9	b=.07
closest neighbors:				
average age	55	58	58	e=.12
% 60+	42	54	55	e=.14

1 All differences are significant at p=.05.

2 Controlling functional health, occupational prestige, and education.

Table 10. Naming 60+ neighbors among neighbors respondent is friendliest with, by neighborhood age structure (for respondents knowing at least one neighbor well).

	PCT60			PCTOP		
# 60+ neighbors:	2-11%	12-22%	23+%	2-10%	11-29%	30+%
0	38.5%	33.8%	19.7%	45.7%	30.6%	19.0%
1	42.2%	30.2%	46.7%	35.8%	42.9%	36.9%
2	12.0%	25.4%	23.0%	9.8%	14.3%	32.9%
3	7.3%	10.5%	10.7%	8.7%	12.2%	11.1%
	100%	100%	100%	100%	100%	100%
N	192	334	122	173	98	252
	X^2=29.5 (6df), p=.0001			X^2=54.3 (6df), p=.0001		

Table 11. Partial correlations (controlling functional health, occupational prestige, and education) of neighbor variables with measures of well being.

	Morale	Mastery	Service Knowledge
# known	.06	.07	ns
# for emergencies	.09	.06	ns
Frequency	.08	ns	ns
Help received	ns	ns	ns
Whether see neighbors enough	.15	.13	ns
Name any 60+	ns	ns	.12
Average age	ns	ns	.10
% 60+ named	ns	ns	.10

Table 12. Regression of morale on health, SES, social ties, instrumental and expressive support, neighborhood involvement, and use of neighbors for instrumental/expressive support (standardized regression coefficients).

	y=Morale		
Functional health	.35	.35	.35
Education	.18	.18	.18
Occupational prestige	.10	.10	.09
Nonneighbor social ties in SMSA	.08	.08	.08
Instrumental help	.08	.08	.09
# of confidants	.02*	.01*	.01*
# neighbors known		.02*	.02*
Neighbor frequency		.06	.06
Help received from neighbors		-.03*	-.01*
Neighbor as confidant			-.01*
Neighbor as instrumental helper			-.04*
R^2	.193	.196	.198

*ns at p=.05 N=780

Table 13. Regression of morale and service knowledge on functional health, SES, social ties, instrumental/expressive support, and involvement with neighbors aged 60+ (standardized regression coefficients).

	y-Morale		y=Service Knowledge	
Functional health	.38	.38	.07	.06
Education	.15	.15	.13	.12
Occupational prestige	.07	.07	-.05*	-.05*
Social ties	.08	.08	.09	.08
Instrumental help	.10	.10	.05	.04*
# of confidants	.01*	.01*	.06	.05
Naming any 60+ neighbor as:				
Confidant		-.02*		-.04*
Instrumental helper		-.04*		.04*
Friendliest neighbor		.02*		.12
R^2	.203	.206	.058	.074

*ns at p=.05

N=888

Table 14. Regression of morale on functional health, education, occupational prestige, social ties, instrumental/expressive support, and whether neighbors are seen enough (standardized regression coefficients).

	Y=Morale	
Functional health	.36	.35
Education	.17	.18
Occupational prestige	.10	.10
Social ties	.08	.08
# of confidants	.01*	.00*
Instrumental help	.08	.07
Instrumental help in neighborhood	.04*	.03*
See neighbors enough		.14
R^2	.199	.219

*ns at p=.05 n=830

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